King County

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RE: Final 2003 Position Statement and Recommendations Regarding Case Manager Turnover

Dear Mr. Shoenfeld:

Thank you for your letter dated March 11, 2003, which was referred to the Quality Council (QC) for review.

As you may know, the Quality Council has been very diligent in following up on the 2000 Case Manager Turnover Study since Ron Sterling became the QC chairperson. This letter constitutes the QC's Final 2003 Position Statement and Recommendations.

At the May 27, 2003 Quality Council meeting, which was well-attended, the QC finalized its discussions of case manager issues, which began during the July 2002 meeting, with the drafting of a letter to providers to encourage case managers to participate at QC meetings. Subsequent discussions and follow-up included a comprehensive review and discussion of the Case Manager Turnover Study published December 2000, which had not received appropriate follow-up. The QC members then originated a draft letter which was finalized and sent by Howard Miller to the King County Mental Health, Chemical Abuse and Dependency Service Division (KCMHCADSD) in late February.

The QC has discussed the KCMHCADSD March 11, 2003 response and has considered (1) other data that is available, such as the KCMHCADSD Geographic Distribution Survey of 2003 (2003 Distribution Survey), (2) the UBH document of July 2002 entitled "Employee Morale and Retention Within the Provider Network" (July 2002 UBH Report) (3) a letter and other anecdotal

information from consumers and families of consumers, and (4) direct input from a few case managers.

On May 27, 2003, the QC authorized the QC Chair, Ron Sterling, to draft a proposed "final" letter to the KCMHCADSD noting QC concerns and recommendations, albeit, the QC is aware that such recommendations may be difficult to achieve given continuing budget restrictions and other challenges. It is the QC's position that since its mandate is advisory, it has an obligation to make observations and recommendations whether the recommendations may be considered "realistic" by the KCMHCADSD or not. This letter is in the form as approved by the King County Mental Health Advisory Board on July 8, 2003.

As noted in your letter of March 11, the QC is aware that the "KCMHCADSD has very little purview over individual provider policies and procedures related to case manager salary, benefits, and general working conditions" and that "It would not be reasonable for us to insist on specific practices that meet our needs but do not accommodate these other realities." You note that those other realities are that "We are only one of the payers with which most providers contract, and providers develop their specific business practices to accommodate multiple payers as well as their own business and treatment philosophies and financial needs."

Questions Presented and QC Findings

1. Was the case manager turnover rate reported in the 2000 Case Manager Turnover Study higher than that reported as typical in the literature?

Answer: Yes.

2. Does case manager turnover continue to be higher than that reported to be typical?

Answer: Yes. However, there has been anecdotal provider feedback that due to current economic conditions and high unemployment figures, there appears to be a trend for case managers to stay in current positions out of the apparent lack of alternative employment.

3. Do high turnover rates have a negative impact on consumer care and treatment outcomes?

Answer: Yes. We find that discontinuity in care is a common consequence of high turnover rates and that it more likely than not contributes to increased costs to the KCMHCADSD and the community and negatively impacts quality of care and quality of life due to missed appointments, interrupted or delayed treatment plans, poor follow-up and, thus, increased client symptomlogy, disability, crises, and confusion.

4. What contributes to high turnover rates?

Answer: The 2000 Case Manager Turnover Study showed the number one reason for leaving was low pay. After that, the factors were quality of client care in a managed environment, frequently-changing system requirements, and inability to provide appropriate care, provider environment, caseload size, and job stress. Lack of system recognition was a factor for those who were *contemplating* leaving.

5. What contributes to low turnover rates?

Answer: Higher pay, greater benefits, decreased caseload sizes (more case managers), decreased or streamlined paperwork, case manager team development and support, recognition at both the system and agency levels.

6. Are there case manager-related concerns other than turnover that impact consumer care and outcomes?

Answer: Yes. We find that there are two other important factors: (1) high case manager caseloads negatively impact quality of care and more likely than not contribute to increased costs to the KCMHCADSD due to missed tasks, delayed interventions, poor follow-up and, thus, increased client symptom logy, disability, crises, and confusion, and (2) low case manager morale negatively impacts quality of care by increasing case manager "burnout," which increases case manager turnover. Low morale is intuitively recognized as a factor contributing to lowered quality of care, reduced investment in job tasks, reduced investment in outcomes, and absenteeism.

7. Is the role of the case manager and the services they offer a significant variable in the equation of providing quality mental health care?

Answer: Yes. Although no study has been done and no particular analysis has been made that the QC is aware of, we find that the tasks assigned to case managers and the role that they play in the provision of services to consumers is a very significant treatment outcome variable.

8. Can the KCMHCADSD have any impact on case manager turnover?

Answer: Some. According to your May 11 letter, the KCMHCADSD *cannot* impact what has been cited as the most important factors in case manager turnover: low pay, provider environment, caseload size, and quality of client care in a managed environment.

9. What positive impact can the KCMHCADSD have on case manager turnover and case manager morale?

Answer: According to your letter of March 11, the KCMHCADSD *could* address turnover and morale through facilitating opportunities of case manager cross-agency communication.

10. Does the fact that the KCMHCADSD conducted an extensive survey in 1999 and published the results of that study and recommendations in 2001, but has failed to publish or communicate about any follow-up on any of the recommendations that were made in that study negatively impact case manager morale?

Answer: Probably. Although the QC has only anecdotal feedback regarding this concern and there has probably been a 30% to 50% turnover in case managers since January 2001, it is not likely that *current* morale is significantly impacted because of published recommendations that have yet to be followed up on. However, the December 2000 Study is posted on the KCMHCADSD Web site (http://www.metrokc.gov/dchs/mhd/qc/turnover.htm) and no follow-up is published there. (See attachment for Web-posted cover letter regarding the December 2000 study.) The QC finds the lack of follow-up as promised in the Web-posted letter dated January 9, 2001, at a minimum, embarrassing.

Please note that the Web-posted letter states "The next step will be to ensure that system improvements are pursued."

Recommendations

While the QC recognizes that the KCMHCADSD has instituted some mechanisms for encouraging providers to retain and to focus on retention of case managers, the QC has the following recommendations.

A. The KCMHCADSD focus on developing strategies for increasing case manager pay or decreasing (regulating) case manager case loads and consider writing to the State's Mental Health Division and appropriate legislators about their concerns and proposals. Case manager turnover likely contributes to increased costs and increased disability, recidivism, relapses, and lowered quality of care and quality of life. As has been pointed out repeatedly over the last three years, this is not a problem that is going to go away *without* appropriate attention and it is a problem that we feel deserves much more attention than it is getting.

B. Our finding that case manager turnover likely contributes to poorer outcomes is based on anecdotal and other information. We understand that further studies may not be possible, but we would be interested in continuing to discuss methods and options for gathering data with respect to measuring outcomes after case manager changes, missed appointments, and other factors related to case manager turnover or high caseloads.

C. The KCMHCADSD form a Case Manager Work Group that consists of case managers, provider representatives (possibly Quality Improvement managers) and consumers, with a mission to discuss and find ways to decrease turnover rates and increase morale in spite of budget restrictions. This may involve some work on the KCMHCADSD's part to encourage providers to allow case managers to participate in such a work group.

D. The KCMHCADSD form a Paperwork Reduction Work Group to find ways to reduce paperwork and to encourage among providers appropriate paperwork reduction. Such a paperwork reduction mission may include facilitating shared best practice examples among providers.

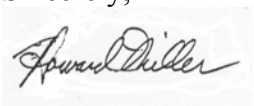
E. The KCMHCADSD assist in scheduling a regular professional peer group meeting for Quality Improvement Managers, with the mission to improve quality on a system-wide basis and to look at case manager turnover issues and how it impacts quality of care.

F. The KCMHCADSD assist the QC in drafting a letter to case managers letting them know what the QC and the KCMHCADSD have been doing with respect to the Case Manager Turnover Study recommendations. Such a letter might come at a time when the KCMHCADSD has authorized the convening of a Case Manager Work Group. In any event, if such a work group is not convened or deemed to be attainable, it is recommended that a letter still go out in the near future reporting the efforts being made to follow up on recommendations in the 2001 Report. In addition, such follow-up report should be posted on the same Web site as the January 9, 2001, letter.

Conclusion

Thank you for your assistance in the past, and your responsiveness. And, thank you for your kind attention to these matters. We hope to continue to carry on this dialogue and periodically revisit these important issues.

Sincerely,



Howard Miller, Chair
King County Mental Health Advisory Board

Ron Sterling, M.D, Chair Quality Council
King County Mental Health Advisory Board

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Enclosures

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